STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005012	A. BUILDING: _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH REGIONAL MEDICAL CENTER	5215 HOLY CROSS PKWY MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State complaint. Date of survey: 04/8/2015 Facility number: 005012 Complaint number: 00152992 Substantiated; no deficiencies related to the allegations are cited. Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.5-1, Dietary Services, 410 IAC 15-1.5-6, Nursing Service and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules. QA: cjl 04/28/15	S 000		